



MRI BREAST QUESTIONNAIRE

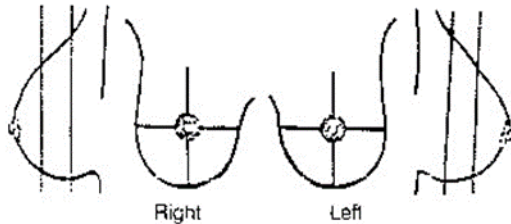
PATIENT NAME: _____ DOB: _____
Last 4 numbers of SS#: _____ Referring Physician: _____

* NOTE: COPY MOST RECENT BREAST QUESTIONNAIRE AND ATTACH

Date and location of recent Mammogram: _____
Date and location of recent Breast Ultrasound, if available: _____
LMP: _____ *For High Risk Screening, Family History, Follow-up MRI recommended Day 7-14 of menstrual cycle.
Hormone Replacement Therapy: _____

Reason for MRI:

Palpable Mass: Please diagram below.



Abnormal Mammogram or Breast Ultrasound: Right Left Breast Implants:

Age of Implants: _____
Type of Implant: Silicone Saline Double Lumen
Clinical Problem: _____

(Change in contour, suspect rupture, palpable abnormality, abnormal mammo, location, side) Recent Breast

Cancer Diagnosis/Staging:

Date of Biopsy: _____
Type of Biopsy: Core Needle Biopsy Surgical Excision
Side and Location in Breast: _____
Where was Biopsy Performed: _____
Histologic Type of Cancer: _____
Follow-up Lumpectomy to Confirm Excision: _____ Please Fax Path Report.

Assess for Recurrent Cancer:

Cancer on which Side? Right Left
Approximate date of diagnosis: _____
Post Mastectomy, Date: _____
Post Lumpectomy, Date: _____
Post, Radiation, Date: _____
Last Chemotherapy, Date: _____
Current Symptoms: _____
Possible Recurrence in Breast Reconstruction
Type of Surgery: _____

Type of Biopsy: Core Needle Biopsy Surgical Excision

- Positive Axillary Nodes: Search for Primary Cancer
Monitor Response to Neoadjuvant Chemotherapy
High Risk BRCA1, BRCA2
Family Hx of Breast Cancer

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____ MS 142 Rev. 12/15